BEFORE THE DEPARTMENT OF PUBLIC
HEALTH AND HUMAN SERVICES OF THE
STATE OF MONTANA

In the matter of the adoption of New Rules I through VIII pertaining to Surveillance and Utilization Review Section (SURS) program-integrity activities to prevent, identify, and recover erroneous Medicaid payments as outlined under federal or state law	))))))))	NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION

TO: All Concerned Persons

1. On March 9, 2017, at 1:30 p.m., the Department of Public Health and Human Services will hold a public hearing in the auditorium of the Department of Public Health and Human Services Building, 111 North Sanders, Helena, Montana, to consider the proposed adoption and amendment of the above-stated rules.

2. The Department of Public Health and Human Services will make reasonable accommodations for persons with disabilities who wish to participate in this rulemaking process or need an alternative accessible format of this notice. If you require an accommodation, contact the Department of Public Health and Human Services no later than 5:00 p.m. on March 1, 2017, to advise us of the nature of the accommodation that you need. Please contact Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; telephone (406) 444-4094; fax (406) 444-9744; or e-mail dphhslegal@mt.gov.

3. The rules as proposed to be adopted provide as follows:

NEW RULE I PROGRAM INTEGRITY: PURPOSE AND SCOPE (1) The department conducts program-integrity activities to prevent, identify, and recover erroneous payments. The department may conduct program-integrity activities, or designate agents to do so, for all health care expenditures funded through Titles XIX and XXI of the Social Security Act or appropriations by the Montana Legislature.

(2) The rules in this subchapter apply to Surveillance and Utilization Review Section (SURS) program-integrity activities to recover improper payments when fraud is not suspected. Fraud and suspected fraud program-integrity activities are not within the scope of these rules. Recovery Auditor Contractor (RAC) program audit and other audits required by federal and state law are also not within the scope of these rules.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE II PROGRAM INTEGRITY: DEFINITIONS (1) "Algorithm" means the set of rules applied to claim or encounter data to identify overpayments.

(2) "Audit" means an examination of a provider's claims data or records, or both, to determine whether the provider has complied with applicable rules, regulations, policies, and agreements.

(3) "Credible allegation of fraud" means an allegation, which has been verified by the department, from any source. Allegations are considered credible when they have indicia of reliability and the state Medicaid agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis. Allegations may include the following:

(a) fraud hotline complaints;

(b) claims data mining; or

(c) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

(4) "Data mining" means using software to detect patterns or aberrancies in a data set.

(5) "Department" means the Montana Department of Public Health and Human Services.

(6) "Extrapolation" means a method of estimating an unknown value by projecting the results of a sample to the universe from which the sample was drawn.

(7) "Elevated-risk providers" means a provider who within the previous six years and three months:

(a) has either admitted to fraud or abuse in a written agreement with a governmental agency or has been determined by a final order of judgment of a governmental agency or court to have committed fraud or abuse; or

(b) has a documented history of a significant error rate that has been sustained over a period of at least six years and three months and that documented educational interventions have failed to correct.

(8) "Follow-up audit" means a follow-up examination of the same type of claims data reviewed in an initial audit.

(9) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. Fraud includes any act that constitutes fraud under applicable federal or state law.

(10) "Improper payment" means any payment by the department that was more than or less than the sum to which the payee was legally entitled.

(11) "Initial audit" means an initial examination of claims data, provider records, or both to determine whether the provider has complied with applicable Medicaid rules, regulations, policies, and agreements performed in accordance with [New Rule IV].

(12) "Investigations" means a formal inquiry or systematic examination or research of someone or something.

(13) "Prepay review" means department analysis of provider claims prior to payment.

(14) "Provider with significant error rate" means a provider who fails to comply with applicable rules, regulations, policies, education or agreements and has one of the following circumstance in a previous review:

(a) billing errors greater than 5% of the total lines reviewed;

(b) total overpayment amount of $1,000 or greater; or

(c) extenuating circumstances that would have evidence of Medicaid waste or abuse.

(15) "Record" means any written or electronic document or record required to be maintained by a provider under ARM 37.85.414.

(16) "Review" means an examination of claims data, a provider's records, or both, to determine whether the provider has complied with applicable rules, regulations, policies, and agreements. The terms "audit" and "review" are used interchangeably in these rules.

(17) "Self-audit" means an audit conducted by the provider and reviewed by the department.

(18) "Universe" is a statistical term that means the entire aggregation of items from which samples can be drawn. In the context of this subchapter "universe" refers to a defined population of claims, encounters, or both.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE III PROGRAM INTEGRITY: ACTIVITIES AND SCOPE

(1) Surveillance and Utilization Review Section (SURS) is part of the department's Quality Assurance Division. Its program-integrity activities include:

(a) conducting pre-payment reviews;

(b) conducting initial audits or reviews;

(c) conducting follow-up audits or reviews on providers with significant error rates;

(d) conducting investigations;

(e) initiating and reviewing self-audits;

(f) applying algorithms to claim or encounter data; and

(g) verifying provider compliance with applicable laws, rules, regulations, and agreements.

(2) Except for fraud investigations, the department must provide written notice at least ten calendar days before conducting program-integrity activities at a provider's premises. Program-integrity activities may occur:

(a) on the department's premises;

(b) on the premises of a designated agent; or

(c) on the premises of the provider.

(3) As described in ARM 37.85.414, a provider must maintain records to support the claims it bills to Medicaid. The department has the authority to review provider records in support of claims. The department may select claims and records to evaluate by:

(a) applying algorithms;

(b) data mining;

(c) claim review;

(d) encounter review;

(e) sampling;

(f) referral; or

(g) applying any other method, or combination of methods, consistent with applicable law and rules designed to identify relevant information.

(4) Only records selected by the methods in (3) will be requested. The provider does not have to supply all records in the universe when sampling is used.

(5) An initial audit or review will typically request records for claims paid within the prior three years and examine claims data generated up to a six-month period except:

(a) when requested by state or federal Medicaid authorities;

(b) when instructed by the Medicaid fraud control unit;

(c) when investigating a credible allegation of fraud; or

(d) when conducting a follow-up audit.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE IV PROGRAM INTEGRITY: PROVIDER SELF-AUDITS

(1) The department may require a provider to self-audit.

(a) The department will give written notice to the provider of the instruction to self-audit.

(b) The provider must return acknowledgement of the receipt of the notice within 30 calendar days of the mailing date of the notice. If the department does not receive acknowledgment within 30 days, it may open an audit.

(c) The provider must comply with all terms included in the notice within the time specified in the notice, unless the department has granted the provider a written extension. Failure to comply with the notice within the time specified in the notice or any written extension constitutes failure to comply with a program-integrity activity.

(d) The department will not require a provider to self-audit any services or encounters that are included in an active state or federal program-integrity activity, rate adjustment, cost settlement, or other payment adjustment.

(e) Within 90 days of receipt of the provider's self-audit, the department will review the self-audit and notify the provider in writing whether it accepts or rejects the results of the self-audit. If the department rejects the results, it may:

(i) instruct the provider to repeat the self-audit; or

(ii) audit the provider.

(2) The department will not accept any identified overpayment as full or final repayment before its review of the provider's self-audit findings is completed.

(3) The provider's notice, dispute, and appeal rights under this section are identical to its rights during or regarding an overpayment determination or other adverse action resulting from an audit conducted by the SURS. The provider has the right to appeal any adverse action that is based on the outcome of a self-audit.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE V PROGRAM INTEGRITY: RECORDS REQUEST (1) A department request for a provider's records to substantiate a claim for payment must

be in writing and dated. The request must include information to allow the provider to identify the particular records sought.

(2) A provider must submit all requested records within 30 days of the date of the request for records, per ARM 37.85.414. A provider may submit records electronically. The department has the discretion to grant the provider additional time to comply with the request for records. Any extension granted by the department must be in writing.

(3) If a provider fails or refuses to comply with a request for records, the department will take one of the following actions:

(a) deny the provider's claim in a prepay review;

(b) issue a draft audit report or preliminary review notice;

(c) issue a final audit report or notice of improper payment; or

(d) as described in ARM 37.85.414.

(4) A provider must retain all records and supportive materials until the program-integrity activity is completed and all issues resolved.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE VI PROGRAM INTEGRITY: EXTRAPOLATION (1) The Surveillance Utilization Review Section (SURS) will not use extrapolation in an initial audit. For elevated-risk providers, the SURS unit may determine the amount of an overpayment by extrapolation based upon statistically valid sampling methods, rather than by audit of the entire universe of claims under review.

(2) Extrapolation may be incorporated in follow-up audits when statistically valid sampling methods have been used. The calculation of overpayments may be based on extrapolation.

(a) To determine an improper payment from a statistical sample, the department may extrapolate to the universe from which the statistical sample was drawn.

(b) If during the course of the audit, the provider adjusts or rebills a claim or encounter that is part of the audit sample or universe, the original claim or encounter amount remains in the audit sample or universe.

(3) Under ARM 37.85.416, statistical sampling and extrapolation on hospital services may not be used.

(4) If the department chooses to use statistical sampling and extrapolation to determine an overpayment, it will use a statistical method to draw a random sample of claims for the review period and will audit these claims.

(a) For an initial audit with no extrapolation, the errors found within the sampled records requested and reviewed will be all that is used to determine an overpayment.

(b) For a follow-up audit with no extrapolation, the errors found within the sampled records requested and reviewed will be all that is used to determine an overpayment.

(c) For a follow-up audit with extrapolation, the errors found within the sampled records requested and reviewed will be factored back into the universe of claims under ARM 37.85.416.

(5) When the department uses the results of an audit sample to extrapolate the amount to be recovered, it will notify the provider pursuant to ARM 37.85.416.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE VII PROGRAM INTEGRITY ACTIVITY: OUTCOMES (1) After reviewing a provider's records, claims, encounter data, or payments, the department will issue a program-integrity review final report that will include any notice of adverse action.

(2) Based upon a program-integrity review final report, the department may take one or more of the following actions:

(a) provide education and guidance;

(b) require the provider to submit additional documentation;

(c) require the provider to submit a claim adjustment;

(d) require the provider to submit a new claim;

(e) deny a claim;

(f) adjust or recover an improperly paid claim;

(g) request a refund by check of an improper payment;

(h) refer an overpayment for collection, with interest and penalties if applicable;

(i) issue a notice of overpayment determination;

(j) impose sanctions under ARM 37.85.501; or

(k) determine it has sufficient evidence to make a credible allegation of fraud.

(3) The provider must submit a claim adjustment or a new claim within 60 calendar days of the date of the department's written notice of an overpayment determination or less if the claim's timely filing, 365 days from the date of service, is less than 60 days.

(4) A department overpayment determination must be dated and include a written description of the overpayment, the dollar amount of the overpayment, the department's reason for determining an overpayment, and the provider's appeal rights.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

NEW RULE VIII PROGRAM INTEGRITY ACTIVITY: DUE DATES FOR PROGRAM-INTEGRITY REVIEW FINAL REPORTS (1) The department will attempt to complete program-integrity review final reports within 90 days of the date the department receives all requested records. If the department's program-integrity activity requires more than 90 days, it will notify the provider in writing of the delay.

(2) The following program-integrity activities and outcomes will be reported via the department's web site:

(a) the number of audits opened in the month;

(b) the number of audits closed in the month;

(c) list of provider types under review;

(d) average number of days for a review; and

(e) the top five review findings.

AUTH: 53-2-201, 53-6-113, MCA
IMP: 53-2-206, 53-2-207, 53-6-101, 53-6-111, 53-6-160, MCA

4. STATEMENT OF REASONABLE NECESSITY

The Department of Public Health and Human Services (department), or its predecessors, has paid claims and recovered overpayments through Surveillance and Utilization Review Section (SURS) program-integrity activities since the creation of the Medicaid program. The department is proposing to adopt administrative rules now to inform the public of its SURS program-integrity activities and give an opportunity for public comment.

Montana Medicaid and CHIP/Healthy Montana Kids (HMK) are jointly funded federal and state programs administered in Montana by the department. State and federal taxpayers' money is used to pay health care providers' claims for services. Program-integrity activities review claims for compliance with Medicaid and CHIP/HMK program requirements and recover overpayments.

The majority of the CHIP/HMK program is administered through a third-party administrator. These rules apply to the program areas administered by the department. Health care providers who choose to enroll as Medicaid providers agree to bill claims and receive payment according to the Medicaid program requirements and state and federal law. Like other health care plans, Medicaid has restrictions and requirements on providing services and coding claims. Federal law requires the department to implement a SURS unit that safeguards against unnecessary or inappropriate use of Medicaid services and against excess payments.

New Rule I

The department is proposing this rule as introductory text to state the purpose of SURS' program-integrity activity. The department is also proposing this rule to explain that the new rules, which will be numbered as a new subchapter to Title 37, chapter 85, apply to SURS audits only. The department has several provider claims payment audit or review programs and participates in federal audit programs.

New Rule II

The department is proposing this rule to provide the definition of terms that may not have a commonly understood meaning.

New Rule III

The department is proposing this rule to describe the program-integrity activities SURS performs and state how these activities are conducted. This is necessary to provide transparency.

As described in the rule, SURS has several processes to review paid provider claims for accuracy. These methods are commonly used throughout the industry to review paid medical claims. SURS only performs follow-up audits of a provider if the initial audit established significant errors resulting in overpayment. SURS uses a broader scope of review in follow up audits.

SURS may use statistical sampling during any activity. This is necessary to perform accurate reviews. It is also an advantage to providers because the entity being audited is only required to provide records supporting the sample size, not the universe of records.

This rule states that a provider must maintain records to support the claims it bills to Medicaid. This is not a change in practice. The department is including this language to clarify that the SURS program does not establish a minimum or maximum time period during which a provider must maintain records.

Section (5) of this proposed rule states the time limits SURS typically applies when reviewing claims and selecting records. This section is necessary to inform providers and the public of SURS practices. Typically, an initial SURS audit is a review of up to six months of claims that have been paid within the prior three years. If the initial audit or review establishes the provider has billing errors in those claims, SURS may expand its review. The rule also lists the exceptions when the time limits do not apply to an initial audit.

New Rule IV

The department is proposing this rule to explain what is required when a self-audit request has been received by the provider. As one of its SURS program-integrity activities, New Rule III(1)(e), SURS may require a provider to re-exam a series of claims it submitted and received payment for. Self-audits are not a new practice but this rule is necessary to explain the process to providers and the public. This increases transparency into the process utilized when a provider is informed a self-audit is required.

This rule also states the timelines that apply to the department and states the provider's appeal rights. This is not a change in current practice but is stated in rule to inform the provider of what can be expected during a self-audit of paid claims.

New Rule V

The department is proposing this rule to state what providers are required to do when SURS requests records. The proposed rule is necessary to reduce provider

confusion and to state in rule that a provider may submit records electronically, which is the department's preferred method of receiving records.

This rule should be considered with New Rule III. SURS will determine a statistical significant sample size before requesting records. This assists providers by reducing the number of records that must be provided.

New Rule VI

The department is proposing this rule to inform providers how SURS uses extrapolation. Extrapolation will only be utilized during a follow-up audit, and follow-up audits only occur if the initial audit demonstrates a significant error rate. Extrapolation is a commonly used audit or review procedure that is necessary when there are a substantial number of claims to review.

New Rule VII

The department is proposing this rule to inform providers of the actions the department may take as a result of an audit. The rule also establishes 60 days from the date of the department's written instruction as the maximum time allowed for a provider to submit a claim adjustment or a new claim, except that no claim adjustment or new claim may be filed more than 365 days from the date of service.

New Rule VIII

The department is proposing this rule to establish 90 days from the date the department receives all requested records as the typical time it will be allowed to complete final reports. The rule is also necessary to state the situations when 90 days does not apply and allow the department to inform providers in the event additional time is needed. The rule also informs providers what information is posted on a public web site. The public notification of the audits that were performed and the corresponding results will enhance transparency in the expenditure of taxpayer funds.

FISCAL IMPACT

These rules do not add any requirements, do not impose a fee, or set a rate. No fiscal impact is anticipated.

5. Concerned persons may submit their data, views, or arguments either orally or in writing at the hearing. Written data, views, or arguments may also be submitted to: Kenneth Mordan, Department of Public Health and Human Services, Office of Legal Affairs, P.O. Box 4210, Helena, Montana, 59604-4210; fax (406) 444-9744; or e-mail dphhslegal@mt.gov, and must be received no later than 5:00 p.m., March 31, 2017.

6. The Office of Legal Affairs, Department of Public Health and Human Services, has been designated to preside over and conduct this hearing.

7. The department maintains a list of interested persons who wish to receive notices of rulemaking actions proposed by this agency. Persons who wish to have their name added to the list shall make a written request that includes the name, e-mail, and mailing address of the person to receive notices and specifies for which program the person wishes to receive notices. Notices will be sent by e-mail unless a mailing preference is noted in the request. Such written request may be mailed or delivered to the contact person in 5 above or may be made by completing a request form at any rules hearing held by the department.

8. An electronic copy of this proposal notice is available through the Secretary of State's web site at http://sos.mt.gov/ARM/Register. The Secretary of State strives to make the electronic copy of the notice conform to the official version of the notice, as printed in the Montana Administrative Register, but advises all concerned persons that in the event of a discrepancy between the official printed text of the notice and the electronic version of the notice, only the official printed text will be considered. In addition, although the Secretary of State works to keep its web site accessible at all times, concerned persons should be aware that the web site may be unavailable during some periods, due to system maintenance or technical problems.

9. The bill sponsor contact requirements of 2-4-302, MCA, do not apply.

10. With regard to the requirements of 2-4-111, MCA, the department has determined that the adoption of the above-referenced rules will not significantly and directly impact small businesses.

11. Section 53-6-196, MCA, requires that the department, when adopting by rule proposed changes in the delivery of services funded with Medicaid monies, make a determination of whether the principal reasons and rationale for the rule can be assessed by performance-based measures and, if the requirement is applicable, the method of such measurement. The statute provides that the requirement is not applicable if the rule is for the implementation of rate increases or of federal law.

The department has determined that the proposed program changes presented in this notice are not appropriate for performance-based measurement and therefore are not subject to the performance-based measures requirement of 53-6-196, MCA.

/s/ Geralyn Driscoll	/s/ Marie Matthews for
Geralyn Driscoll, Attorney	Richard H. Opper, Director
Rule Reviewer	Public Health and Human Services

Certified to the Secretary of State December 27, 2016.